ISBVI MAT LAB APPLICATION

Students Name	DOB/Age/Current Grade or Placement
Student's School	LEA/School District
Parent/Guardian's Name (Please Print)	Name of School/Address
Parent/Guardian's Street Address	School City, State, Zip
Parent/Guardian's City, State, Zip	School Phone
Parent/Guardian's Home Phone	Blind/Low Vision Teacher Name
Parent/Guardian's Alternate Phone	Blind/Low Vision Teacher Phone
Parent/Guardian's Email	Blind/Low Vision Teacher Email

Does the student wear glasses/contacts? yes □ no □
Does the student currently use an AT Device? yes □ no □

If so, what devices? _____□

PARENT/ADMINISTRATIVE CONSENT
Parent(s)/Guardian(s): I have read the consent letter and understand the purpose of this program. I give permission for my son or daughter to participate in the MAT Lab program and for the release/exchange of medical/educational information.

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Parent/Guardian Signature Date

Local Educational Agency: Assistive technology assessment services from the MAT Lab are requested for the above student. These services include an assistive technology assessment, an assessment report, assistive technology recommendations and follow-up information and assistance in the school/home from MAT Lab consultants. (There is a $125.00 charge/hour portal to portal charged to the school district for a MAT Lab evaluation)

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LEA / Director of Special Education / Program Supervisor signature Date

Please return completed applications to:
ISBVI Outreach and Related Services Department
Attention: Pat Hertenstein, *Outreach Assistant*
7725 N. College Avenue, Indianapolis, IN 46240
Fax: 317-259-4945